Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number:
M4-13-1916-01

MDFR Received Date
MARCH 26 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I HAVE TRIED CALLING Texas Mutual numerous times. Spoke with Ricky Whitiker on this matter once on 02/11/'13, also sent same copies to them weeks before talking to him, He said that He would need to get back to me. He never returned my calls after that."

Amount in Dispute: $82,482.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: **"**The dispute request is from the injured worker. In reviewing the documents from the DWC-60 packet is not clear to Texas Mutual if the injured worker is seeking payment for himself for out of pocket expenses related to medical treatments over the time frame above or if he is seeking reimbursement for the healthcare providers. If it is the former, there are no receipts submitted showing payments made. If he is seeking reimbursement for the healthcare providers then it is the providers' responsibility to seek that reimbursement. Regardless, the dates above are out of jurisdiction. Rule 133.307(c)(1)(A) states, "…A request for MFDR that does involve issues identified in subparagraph (B) of this paragraph shall be filed not later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(S) of service: (i) a related compensability, extent of injury or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury or liability…" A decision & Order was issued on 5/29/12… This finally adjudicated on 8/31/12, Sixty days from 8/13/12 is 110/30/12. The DWC MDR date stamp packet states the date DWC MDR received the request for medical fee dispute resolution was 3/26/13, a date greater than 60 days from 8/31/12. For this reason DWC MDR has no jurisdiction to rule on the injured worker's request."

Response Submitted by: Texas Mutual Insurance Co., 6210 Hwy. 290 E, Austin, TX

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2009 through June 7, 2012	Out-of Pocket Expenses	Unknown	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - EOBs were not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c)(1)(B)(i)?

Findings

Pursuant to 28 Texas Administrative Code §133.307(c)(1)(B)(i) a request maybe filed later than one year after the dates of service if a related compensability, extent of injury or liability dispute has been filed. The medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive al all appeals, on compensability, extent of injury, or liability. A Decision and Order was issued on May 29, 2012. It was found that the injury included a left inguinal hernia, lumbar radiculopathy, and aggregation of degenerative disc disease and multilevel degenerative joint disease. The respondent appealed this decision and the Appeals Panel upheld the decision on August 31, 2012. The requestor submitted a request for medical fee dispute resolution; this request was received in Medical Fee Dispute Resolution on March 26, 2013, a date greater than 60 days from the final adjudication. Medical Fee Dispute Resolution has no jurisdiction to rule on this dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that no reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.